QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INVESTIGATION

CITATION:	**Non-inquest findings into the death of Karina May Lock and Stephen Glenn Lock**
TITLE OF COURT:	Coroners Court
JURISDICTION:	SOUTHPORT
DATE:	10 September 2021
FILE NO(s):	2015/3553; 2015/3575
FINDINGS OF:	Jane Bentley, Deputy State Coroner
CATCHWORDS:	CORONERS: Domestic and family violence, domestic abuse, mental health, protection orders, heath care providers, service system contact.

Contents

Background

1. Ms Karina Lock was born on 13 November 1965 and died on 10 September 2015 aged forty-nine. Ms Lock was violently killed by her husband Stephen Lock.

2. Ms Lock was married to Mr Lock for over thirty years. They had four children together (S1, S2, D1 and D2). They separated in November 2013.

3. Mr Lock suffered from a psychiatric illness and abused drugs and alcohol for many years. Ms Lock was subject to domestic abuse. Mr Lock's mental illness and domestic abuse escalated in the later years of their relationship. When she left him he shot and killed her in a McDonald's restaurant, and then shot and killed himself.

4. Throughout these findings I examine the response of services to Ms Lock's help-seeking behaviours, and to Mr Lock's domestic abuse.

5. On the morning of 10 September 2015 Ms Lock and her 14 year old daughter (D1) drove to the McDonald's restaurant at Helensvale where they had arranged to meet Mr Lock. Ms Lock had agreed to meet Mr Lock as he said that he wanted to give their daughter a present but she had arranged to do so in a public place because she feared for their safety.

6. They met and had coffee and stayed at the restaurant for about an hour. The three then left in Ms Lock's car to take their daughter to another location. After dropping their daughter off, they drove back to the carpark of the McDonald's restaurant where Mr Lock's car was parked. They arrived there at 8.58am.

7. At approximately 9:00am, David Udinga, who was at the McDonald's restaurant, described hearing a loud noise which he initially thought may have been a starter pistol or car backfiring. He also heard a female screaming, "Help me, help me".

8. Mr Udinga got up and observed the couple struggling in the car. Ms Lock managed to exit the vehicle despite Mr Lock's attempts to pull her back in. She

made her way to an undercover outdoor dining area. She stated, “He’s going to kill me.”

9. Mr Udinga ran to the car and told Mr Lock to stay in the car however Mr Lock exited brandishing a gun (later identified as a black .22 calibre semi automatic pistol). Mr Udinga tried to get Mr Lock back into the vehicle and told him to drop the gun, but Mr Lock aimed the gun at Mr Udinga’s head and said, “Do you want to die?”

10. Mr Lock got out of the car and followed Ms Lock into the restaurant.

11. Mr Lock entered the restaurant and grabbed Ms Lock in a choke hold. They struggled and fell to the ground. Mr Lock put the firearm to the right side of her head and fired the gun. Ms Lock slumped to the ground. He then turned the revolver on himself and shot himself in the head. He fell forward onto Ms Lock.

12. Senior Constable Matthew Gilles was the first to respond to the 000 call which was made at 9.17am. He disarmed Mr Lock and commenced CPR on Ms Lock.

13. Queensland Ambulance Service paramedics attended and attempted CPR on both Mr Lock and Ms Lock. Ms Lock was pronounced deceased at the scene. Mr Lock was conveyed to the Gold Coast University Hospital where he ultimately died as a result of his injuries.

Autopsies

Karina Lock

14. An autopsy confirmed that Ms Lock died from the gunshot wound to the head. The bullet passed almost horizontally through the brain including through the upper part of the brain stem which is the area where respiration and heartbeat are controlled. This injury caused her rapid death.

15. Ms Lock had no significant natural disease. She was otherwise healthy at the time of her death.

Stephen Lock

16. An autopsy confirmed that Mr Lock died from a gunshot wound to the head.

17. He had multiple old scars on the flexor surface of the left forearm and on the medial aspects of both lower legs, consistent with having been self-inflicted. He had severe degenerative narrowing of two of the coronary arteries of the heart, however, this did not contribute to his death.

Investigation by the Queensland Police Service

18. The QPS conducted an exhaustive investigation into the deaths of Ms Lock and Mr Lock and concluded that Mr Lock killed Ms Lock, he acted alone and there was no evidence of involvement by any other person.

19. Police were unable to identify the firearm used by Mr Lock due to the serial number having been removed. Police could not ascertain from where Mr Lock obtained the weapon.

Domestic and Family Violence Death Review Unit

20. The Domestic and Family Violence Death Review Unit (DFVDRU) of the Coroners Court of Queensland considered the circumstances of the deaths of Ms and Mr Lock, the history of domestic abuse and the contact with service systems and whether system responses were appropriate and adequate.

21. A protection order under the *Domestic and Family Violence Protection Act* 2012 (Qld) (DFVP Act) was current at the time of deaths and there was a history of physical and verbal abuse perpetrated by Mr Lock throughout the marriage. Ms Lock had made several unsuccessful attempts to separate from Mr Lock in the past however the couple had recently sold their house and Ms Lock had moved with D1 to the Gold Coast about a month earlier. Ms Lock and D1 were living with her brother and his wife, B and W, who had assisted her and D1 to move.

22. W said in a statement after the deaths that prior to helping Ms Lock and D1 move, B spoke to police about extending the conditions of the order to include

his family as named persons however this was not recorded on police records and there was no application to vary the order.

23. W also stated that during this time the family had been forced to '*box up'* weapons belonging to Mr Lock, alleged to include pepper spray, knives, knuckle dusters and machetes because they feared that Mr Lock may come back and '*it's not normal to have these things in a house'.* Despite their concerns, the move went as planned and Ms Lock and D1 were able to relocate to the Gold Coast.

24. In the weeks before the deaths, Mr Lock had asked to see D1 to give her a gift and Ms Lock arranged for a public meeting out of a concern for their safety, given Mr Lock's history of ongoing mental health and drug related issues and perpetration of (primarily) emotional abuse throughout their marriage. W offered to sit in another car in the carpark as added security however Ms Lock refused the offer.

25. A diary of Mr Lock's was found after the deaths which outlines considerable pre-meditation of killing Ms Lock and plans to harm B and W and other members of their family; and is highly suggestive of a marked deterioration in Mr Lock's mental health.

26. Although undated, the diary appears to have been commenced after Ms Lock moved to the Gold Coast[1].

27. The entries include:

- Multiple references to forcing a reconciliation including that: '*surely our marriage is worth a few days in working out our problems + issues???'*; '*Been married 31 years, worth a few days to see if we can work things out'*; *'This can all be avoided if you make the video, convince your brother + come back as my wife'*.

[1] For example, one of the first entries states: '*Find out B's gate codes and house security code'* which suggests Ms Lock was living with B at the time of commencing the diary.

- Conditions of reconciliation including that '*you will be more affectionate, hold my hands, put arms around me, show affection'*; '*… we will support one another, we will try harder'.*

- Reference to the Jehovah's Witness faith such as '*Are you willing to adhere to organisational + bible principles?? Are you a fake Christian, you cannot pick + choose which principles and laws to obey or not'*; *'We will talk things thru Jehovah's way'*; '*You won't forgive me as Christ says to'*; and '*Marriage is sacred, let no <u>man</u> tear it apart, marriage between man, woman, God'*.

- Threatening comments directed towards B & W based on Mr Lock's view that they were stopping Ms Lock from reconciling such as: '*Everyone can butt out + let us work our marriage out'*; '*Mass blood letting of [B & W] family'*; *'Pick up her car! Not coming home because they will try to talk her out of seeing me + reconsiling* [sic]; *Convince [B & W] family she's alright, spending a few days talking SEE IF WE CAN SORT OUR LIVES OUT where we are both happy';* '*If I am going to live without you, I might as well commit as much destruction on [B & W] family as I can, then suicide'; 'If you betray me again, I will kill every member of the [B & W] family I can before I die'.*

- Several references to [Y] and her father sexually assaulting Ms Lock as a child[2] and Mr Lock seeking revenge or retribution, which included plans to get a video 'confession' from Ms Lock and [Y] which he planned to post on Facebook. The comments include: '*Find out for how long [Y] use her for his own sexual gratification'*; *'You and [Y] have been hiding what you did to each other for 39 years. You and him have colluded to keep what happened between you both a secret. You have both lied to W. You 2 have a very dark secret. TELL ME'*; '*You + your secrecy has allowed [Y] to take a high moral standard against me + he does this with <u>your</u> help when in reality he doesn't have a moral leg to stand on. You will divulge your secret. You 2 did not tell W or the elders the whole truth. It was much more than simulated sex with your clothes on. If we can turn [Y] around we can have a life but only if I have the proof on video'.*

[2] There is no information available to confirm whether this occurred.

- Five apparent 'solutions' are listed and Mr Lock has written, '*You (Karina) pick the scenario 1-5, which one appeals most*':
    1. *'Shoot W, B, [and family members]* + [indecipherable]. *They can have a resurrection. Take my family, will take yours. Leave you alive to suffer'.*
    2. *'Shoot me and you, our kids suffer!!! D1 more so. Do you care???'*
    3. *'Shoot B and myself, maybe W, leave you to explain video + suffer'*
    4. *'Reconcile, talk to B, clear the air, become HAPPY families. All forgive and move positively forward'*
    5. *'Come into K Hall and fire away with auto rifle'.*

28. Mr Lock indicates in this diary that he had considered organising '*hits*' through the Rebels or Odins[3]; and outlined a range of other steps to be taken, including transferring money to the children[4] and providing for them in wills before the fatal event.

29. He further stated that '*something in my head has snapped'* and that he was '*not going to let ANYONE else have her, she was my VIRGIN + marriage is until death do we part'.*

Prior history of domestic abuse

30. Although there were limited formal reports of domestic abuse throughout the marriage, records suggest Mr Lock exhibited a pattern of coercive controlling behaviour towards Ms Lock and that she had previously attempted to end the relationship but had been manipulated into reconciling.

31. Statements and records outline a history of abusive behaviour by Mr Lock including:

32. Emotional and verbal abuse including reports that he commonly spoke to her in a degrading, aggressive and demanding manner in front of others; made derogatory comments about her 'revealing clothing'; criticised her ability to parent the children; and had threatened or attempted suicide or self-harm in her presence.

[3] Outlaw Motor Cycle Gangs.
[4] Mr Lock did transfer money to both S1 and S2, which both said was out of character for their father.

33. Manipulation of Ms Lock including by blaming her for attempting to break up the family when she would attempt to leave him; using the children in an attempt to force reconciliation or remain in the marriage; citing her religious obligation to stay married in accordance with her faith; and, blaming her for ongoing issues with their eldest son, S1.

34. There appears to be limited evidence of physical abuse in the relationship, however Ms Lock's sister-in-law, W, told police that Ms Lock previously disclosed one historical act of non-lethal strangulation. In her statement to police after the deaths, W stated *'she* [Ms Lock] *also said that once he put his hands around her neck. I didn't understand this to be a recent instance and she didn't talk about any other physical abuse. It was more mental abuse.'*

35. A protection order under the DFVP Act was current at the time of the deaths which was initiated after Mr Lock attempted suicide and made threats to burn the family home down if Ms Lock did not return home in November 2013 (outlined in further detail below).

36. Ms Lock's family have indicated she remained afraid of Mr Lock up until the time of her death which is consistent with her decision to meet in a public place on the morning of the fatal assault.

37. There is also evidence that S1, Mr Lock and Ms Lock's adult son, has demonstrated a pattern of coercive controlling violence in intimate partner relationships in at least two relationships which include threats to kill, verbal abuse, stalking and harassment via social media and other means and one reported act of non-lethal strangulation.

38. Most significantly, in 2016 S1 physically assaulted an intimate partner, and threatened to self-harm with a razor and commit suicide in response to his suspicions of her infidelity. The police records indicate that she locked herself in the bathroom with the razor to give S1 an opportunity to calm down, however, he broke into the room and non-lethally strangled her. She managed to escape and contacted emergency services. S1 left and she locked all the doors, however he broke down another door to gain entry into the house. She fled and S1 threatened her with an axe as she attempted to leave the property. With

respect to these offences, S1 was subsequently charged and sentenced to a cumulative period of imprisonment of two years and six months.

39. More broadly, his criminal history is extensive and includes a range of charges in relation to drug-related offences, property and theft charges as well as assault and other acts of violence (directed towards non-intimate partners or family members) which has resulted in a range of sanctions (including periods of imprisonment) from as early as 2005, when S1 was only 16 years old.

40. Although not a core focus of this review there are clear indicators of the abusive behaviour being transmitted intergenerationally within this familial network[5].

Service system contact

41. Noting the persistent impact of Mr Lock's mental illness and drug use on his behaviour and marriage, it is perhaps unsurprising that the majority of system contact prior to these deaths was with health services pertaining to his clinical care management; however there was also recorded contact with police prior to these deaths with respect to violence within the immediate familial network.

Queensland Police Service

42. Following these deaths, the QPS completed an audit of contact which outlines a limited history of contact for both Ms Lock and Mr Lock with the QPS.

43. A protection order under the DFVP Act was established after an episode of violence on 16 November 2013 when Ms Lock returned from an interstate holiday which she had taken without her husband. Upon her return, Mr Lock had expressed anger about Ms Lock wearing revealing clothing before going to the garage where he climbed a ladder and attached a rope to the beam. Ms Lock and D1 (then aged 12) witnessed this behaviour and pleaded with Mr Lock

[5] Intergenerational transmission of violence whereby it is theorised that children exposed to violence in their family of origin may be more likely to perpetrate, or be a victim of, violence in future intimate partner relationships. Research suggests that this may arise as children learn that violence is an effective means of resolving conflict or gaining control; or because they may develop attitudes to justify their own use of violence. See more here: VicHealth study cited in Flood, M. & Fergus, L. (2008). *An assault on our future: the impact of violence on young people and their relationships*. Sydney: White Ribbon Foundation. Edleson, J. (1999). Children's witnessing of adult domestic violence. *Journal of Interpersonal Violence, 14(8)*, 839-870.

to stop. This prompted him to run into the house, grab a bottle of alcohol and then locked himself in the master bedroom where he proceeded to cut his wrists with a knife. Mr Lock escaped from the room via a window and cut his wrists, forearms and lower legs in the garage before police arrived and conveyed him to the Maryborough Base Hospital (MBH) under the Emergency Examination Order (EEO) provisions of the *Mental Health Act* 2000 (Qld) (MHA 2000).

44. This event followed another episode of self-harm several weeks earlier where Ms Lock observed evidence of self-inflicted cuts to Mr Lock's wrist which had occurred while she was away on holidays.

45. While under mental health review at the MBH Mr Lock absconded from hospital prior to being assessed. Mr Lock returned to the family home and scratched the words '*I can't believe you have done this to me'* on the bonnet of Ms Lock's car before making a series of continuous phone calls to Ms Lock threatening to burn the house down and complete suicide if she did not return home. Mr Lock also expressed that he felt there was '*no need to live'*.

46. Police were again called to respond and located Mr Lock at the family home on the morning of 17 November 2013. He stated he needed help and was subsequently transported by police to the MBH for assessment subject to the EEO.

47. Responding officers undertook a risk assessment in accordance with the Domestic Violence Protective Assessment Framework (DV-PAF) and determined there was a *high* level of risk based on the following factors:
    - **Category 1:** previous incidents/breach, severity, threats to kill, use of weapons., cultural considerations, stalking, violent threats,
    - **Category 2:** Alcohol/drug misuse, controlling behaviour, mental health issues, significant damage/destruction of property, suicidal, violent threats.
    - **Fear:** fearful

48. Additional collateral information obtained from Ms Lock by police officers was also used to inform the decision to seek a protection order on behalf of Ms Lock and the children, including that Mr Lock:

- had always displayed controlling and jealous behaviour in his relationship with Ms Lock;
- blames Ms Lock for their issues;
- his behaviour is escalating and Ms Lock is afraid that he will hurt her, the couple's children or himself; and
- he was experiencing mental health issues concurrent to substance misuse.

49. The two year protection order was made in the Maryborough Magistrates Court on 2 December 2013 requiring that Mr Lock (respondent) be of good behaviour and not commit domestic violence against Ms Lock (aggrieved) and three of their children, D1, S2 and D2 (named persons), and further that he not commit associated domestic violence against each child and not expose each child to domestic violence. Police also referred both parties to SupportLink.

50. There were no other formal reports of violence made to police and Ms Lock did not notify police of any potential breaches to the above order, although witnesses have attested that he continued to emotionally abuse Ms Lock until she left.

51. With respect to this second episode of contact, the police conducted themselves in accordance with the relevant provisions of the QPS Operational Procedures Manual and the overall response is commendable.

For example:

- Police officers responded to the immediate threat of safety by transporting Mr Lock to hospital under an EEO and were comprehensive in undertaking a protective assessment and applying for a protection order (standard conditions) which was subsequently granted.
- They also provided referrals to both parties (although neither party made contact with these services according to the homicide audit into these deaths).
- They sought collateral information to inform a thorough risk assessment and justify establishment of a protection order.

52. As outlined above, in a statement made after the deaths, W said that her husband, B, spoke to police before they assisted Ms Lock to move about how to vary the protection order to include them as he was concerned about the potential risk posed to the family once Ms Lock and D1 moved in with them. On review of police records for both the deceased and B, there is no corresponding entry pertaining to this alleged contact and no application to vary the protection order was lodged.

53. More broadly, Mr Lock's occurrence and criminal history indicates:
    - a history of contact in relation to drug-related offences from as early as 1993;
    - some limited evidence of other offences including property, theft and burglary related matters.

54. Ms Lock's contact with police was limited to the isolated domestic violence episode above or as an informant for other unrelated matters.

Health system contact

55. Medical records have been obtained for both Ms Lock and Mr Lock to identify whether there were relevant disclosures about domestic abuse prior to their deaths, and if so, whether appropriate interventions or referrals were made.

56. A timeline is provided following this section, however it is salient to note that:

57. Mr Lock experienced significant mental health issues which were exacerbated by his problematic drug use and commenced as early as 1995; and included periods of involuntary treatment under mental health legislation as recently as 2013.

58. Mr Lock was relatively well engaged with a psychiatrist from Coastal Life Therapies between 2006 and 2015; as well as general practitioners from the Queens Park Medical Centre throughout the same period.

59. Ms Lock also presented with mental health concerns and openly disclosed a history of childhood physical and sexual abuse (by her father and a family

friend, respectively); and had attended hospital with a range of cognitive and physical symptomology which she attributed to ongoing relationship stress.

60. Ms Lock sought medical certification for the purposes of obtaining Centrelink benefits citing her experience as a victim of abuse in a violent relationship with Mr Lock in the weeks before her death.

Queens Park Medical Centre - Mr Lock

61. Patient records indicate that Mr Lock attended this medical centre on at least 11 occasions between 2006 and 2015 in relation to mental health issues including depression and anxiety; substance misuse; family conflict and '*marital problems'* with Ms Lock (including during periods of reported separation); and because of ongoing issues with S1[6].

62. During these sessions, Mr Lock disclosed the following concerns: '*troubled mind'*; intolerance of authority; feelings of separation from society; depression (linked in part to bereavement over the death of his mother); sleep issues; a sense that his religion was interfering with his relationship with Ms Lock; and ongoing concerns related to S1 in the context of his anti-social criminal behaviour, stressors associated with his incarceration, and adjustment issues upon his return to the community.

63. Several mental health assessments were completed by Mr Lock's primary GP over the course of this contact, who also referred Mr Lock to a private psychologist and psychiatrist for further treatment.

64. Mr Lock was a patient at the clinic in November 2013 when he attempted suicide. He disclosed the suicide attempt to his GP and said that '*he had 'lost it' and tried to hang himself one month earlier after S1 was sentenced'*; that Ms Lock blamed him for everything; and that he was '*sick of always being the*

[6] This was described in the medical records as including: a general non-compliance with prescribed medication; binge drinking in combination with anti-psychotic medication; employment and accommodation issues; an unwillingness to change behaviours; and aggression he exhibited towards the family.

asshole'. He further stated that Ms Lock *'blackmails the kids and himself about religion'*.

65. Mr Lock next presented at the clinic almost a year later, on 3 November 2014, when he reported that he was still engaged with the psychologist. He said that his family dynamics had changed and '*Ms Lock was her 'own person' and involved in the church'.* He said that D1 reportedly sided with Ms Lock, while D2 and S1 see that '*there is more than one side'*. Mr Lock said that S2 stays in his room and '*has very little interaction with his parents'*.

66. In the year of the deaths, Mr Lock attended the clinic three times as follows:
    - 23 June 2015: Mr Lock requested a referral for S2 to see the psychologist and spoke of '*his feelings of anxiety, stating he feels fragile, the family is fragmenting and he is trying to help S1*'. On this occasion the clinical notes indicate the doctor increased his anti-depressant medication.
    - 3 August 2015: Mr Lock reported that Ms Lock had left for the Gold Coast and S1 and S2 had moved out of the home.
    - 31 August 2015: Mr Lock reported sleep disturbance and said his '*stomach was in a constant state of agitation*' and that he felt nervous. Mr Lock said that he was living with a friend and was looking for somewhere to live with S2. On this occasion, the GP again increased his medication and noted an intent to follow up with the MBH Mental Health Unit (MHU) for a further review.

67. The GP contacted the MHU regarding a referral on 1 September 2015 which occurred on 3 September 2015. The MHU completed an assessment and contacted the GP to advise Mr Lock had been seen and encouraged to engage in new interests. An emergency plan was given (discussed below) and it was recommended that his medication remain the same.

68. Several mental health care plans were completed during Mr Lock's engagement with the clinic that included referral to private psychologists from Coastal Life Therapies and the Bethesda Clinic.

Coastal Life Therapies – Mr Lock

69. Following referral by his GP, Mr Lock attended four periods of therapy with the psychologist as follows:
    - between 22 December 2006 and 25 October 2011 (attending almost monthly sessions)
    - between 26 June 2012 and 5 December 2012 (six sessions in total)
    - between 3 April and 9 December 2013 (six sessions in total)
    - between 13 January and 30 September 2014 (six sessions in total).

70. This engagement represents the most significant and sustained contact by either deceased with services and although there were no direct disclosures of acts or indicators of domestic and family violence, it is also the case that there were several indicators of more serious underlying mental health concerns that were largely overlooked, particularly between 2006 and 2011.

71. The records suggest:
    - The psychologist did not complete any formal mental health assessments apart from some initial testing prior to diagnosing Mr Lock with Asperger's Syndrome in 2006
    - The psychologist did not follow up with Dr J, a psychiatrist who diagnosed Mr Lock in 2009 with Category B personality traits, particularly narcissism and anti-social behaviour, which he believed was the primary issue rather than Asperger's
    - no risk assessments were completed at any stage, even after Mr Lock disclosed a suicide attempt and in the context of ongoing conflict in the home and Mr Lock's open disclosures of issues managing 'rage'
    - The psychologist did not seek medical records pertaining to Mr Lock's suicide attempt in 2013 which constituted an act of domestic and family violence and represented the start of a marked decline in Mr Lock's mental health
    - no referrals to the other services were made during this period of time

- Mr Lock disclosed some significant and disturbing symptoms at an early stage including experiencing auditory hallucinations and carrying needles so people wouldn't get too close to him.

72. The following section summarises this contact and although some of this occurred several years before the death it provides some context to Mr Lock's mental health problems in the lead up to the death over the course of the psychologist's treatment.

22 December 2006 to 25 October 2011

73. With respect to the first period of therapy with the psychologist between 2006 and 2011, Mr Lock was diagnosed with Asperger's Syndrome after reporting significant levels of anxiety and frustration in relation to his inability to fully understand social situations.

74. The psychologist completed a series of tests before this diagnosis, however it is salient to note that during his first session on 22 December 2006, Mr Lock disclosed some concerning behaviours with the clinical notes indicating:
    - '*he went down Rundle Mall with needles in his hands so people wouldn't get too close'*
    - *'voices in head where he is starting to think/ruminate over things in his head'* and '*gets thoughts this is not the place to be'.*

75. He further disclosed a family history of mental illness including bipolar disorder; that he had '*anger and grudge against religion and feels he and his wife have been abused by the church*'; that he had been bullied as a child but *'found a large nail and stabbed the bully in the knee*'; and commonly experienced '*raging anger*'. He also disclosed that he and Ms Lock had a lot of fights over religion and the way he perceived her family treated him which prompted him to disclose homicidal intent, specifically that he would '*like to kill 1, maim others'*. He said he loved his wife and children but '*interference makes me unstable inside and mentally'*.

76. Issues with Ms Lock's family continued to be a source of conflict for Mr Lock throughout his course of sessions and he stated several times he was

struggling to reconcile their treatment of him. He further stated Ms Lock had confronted her brother about these issues. After several sessions, Mr Lock disclosed that he was experiencing marital problems because of the couple's conflict over religion, his use of marijuana and his excessive rage; and that Ms Lock was going to Adelaide with the children for a break.

77. Mr Lock said things were better upon her return although he continued to have trouble with his rage and he felt unstable in the relationship, disclosing that he lacked trust in Ms Lock (although he did not expand on this). Other issues discussed were S1's problematic behaviour and techniques to regulate his thoughts and emotions.

78. In March 2008, Ms Lock attended a session to understand more about Asperger's Syndrome but the notes are sparse. On this occasion Mr Lock disclosed an '*obsession with documentaries'*.

79. From this point, the clinical notes describe an ongoing deterioration in the relationship which was causing frequent conflict and was a major stressor for Mr Lock; although no referrals were made to relevant support services who may have been in a position to assist.

80. In September 2008, there is some reference to Mr Lock seeking further support from his GP regarding his mood and anti-depressants were discussed for what appears the first time.

81. Towards the end of 2008, Mr Lock disclosed significant conflict in the couple's marriage including that Ms Lock had accused him of having an affair and he was considering leaving her.

82. In February 2009, Mr Lock cited further problems with Ms Lock's family as she was due to attend a family reunion that the others were attending. The notes indicate that her '*defence of her brothers continued to make him cranky*'; that he '*had enough of his wife and her denial'*; and that he was '*angry and bitter about her attitude*'. Although the records do not indicate disclosure of suicidal ideation, the psychologist's treatment notes for this session included '*Suicide*

is not an option. Look ahead to future and make plans' which suggests there was either some direct discussion or indication of suicidality.

83. Relationship issues continued to be a key focus throughout mid 2009; and the clinical notes show that in September 2009 Mr Lock reported his engagement with Dr J, a psychiatrist from the Bethesda Clinic (summary of contact outlined below). Mr Lock reported that Dr J had recommended no pharmacotherapy was required but was supportive of ongoing psychological support occurring.

84. Throughout the latter part of 2009, Mr Lock continued to cite some concerns with his marriage and the children; but these were less prevalent and the notes suggest he was finding coping strategies and interests (such as a new boat) that were having a positive impact on his daily life.

85. In January 2010, Mr Lock stated that he had been '*off the pot for 3 months and been going to the gym to get fit'* but that he continued to fight with Ms Lock for whom he said '*nothing is good enough'* and was '*extremely unhappy with his situation at home'*.

86. In March 2010, it appears the psychologist reconsidered the potential benefit of anti-depressant medication however it is not until June 2010 that the notes indicate Mr Lock commenced this medication via GP prescription.

87. In April 2010, Mr Lock reported his mother had died and he continued to cite problems with Ms Lock and the children saying that '*he has had some nasty arguments with his wife'*. These themes continued throughout May and June 2010 and Mr Lock said that after the death of his mother, '*he was able to look at his relationship in a new light.* He also again indicated he was experiencing auditory hallucinations, with the notes stating '*says he has voices in his head who rebuke him when he does something wrong'*. The treatment notes for this session include '*challenge the thinking in his head'*.

88. Over four further sessions in 2010, Mr Lock discussed his family situation and cited a loss of sexual libido linked to medication he was taking. He stated that '*his relationship is at a stalemate'* and that the couple continued to have issues, and that he '*feels despondent and bitter that things have gone this way'*.

Ongoing issues with S1's mental health appear to escalate during this same period.

89. In 2011, Mr Lock attended seven sessions with the psychologist. During these sessions, ongoing issues with S1 and the marriage were discussed and it appears Mr Lock was struggling to cope with S1's anger and aggressive behaviour.

90. Of significance, the clinical notes include:

- further reference to auditory hallucinations, such as '*his head has been busy and hasn't been quietening down'*
- statements suggesting that Mr Lock was struggling to cope, such as '*says he feels boxed in/cornered because his thinking is different to others around him'* and '*often feels like he needs to isolate himself from the stress around him'*
- potential indicators of suicidality including '*says he doesn't have much to look forward to in life'*

91. Although there were notes suggesting some issues with Ms Lock, Mr Lock states that '*the relationship appears to be ok*' and this was not a major point of discussion until August 2011. At this time, S1 was living at home again which was a source of conflict.

92. Mr Lock said '*he has shut down with his wife – says she doesn't listen to him'*; that '*he has noticed a pattern where his wife argues with him more often when they get to their anniversary';* and he reported feeling annoyed at how he was being treated and '*says he feels he is being controlled'*.

93. The final session for this period occurred on 25 October 2011. Mr Lock disclosed continued problems with S1 and the children, describing his relationship with Ms Lock as '*up and down'*. He said he had found it hard to give up the pot though had '*trimmed it right back to very small amounts'* and acknowledged that he had been '*taking himself off Lexapro for the past 3 months'.*

94. The treatment strategies discussed with Mr Lock appear largely psycho-therapeutic in nature and include references to asking Mr Lock to contemplate and consider various questions and issues in his life; to pursue hobbies and interests; to try meditation and other relaxation techniques such as time-outs; and some strategies to manage social situations which caused him stress.

95. There is no evidence of referral to other services, including any alcohol and other drug services for his co-occurring cannabis use; and very limited reference to medication as a treatment strategy.

96. Although the psychologist was aware that Mr Lock saw Dr J from the Bethesda Clinic in 2009 (outlined below) there is no evidence of any attempt by the psychologist to contact Dr J to confirm or discuss this, which is significant given Dr J formed the view that the primary issues affecting Mr Lock related to Category B personality traits, including narcissism and anti-social behaviours, rather than Asperger's Syndrome – which appears to have been the primary focus of the psychologist's therapeutic approach. Dr J, as outlined below, wrote to the referring GP who advised the psychologist of the revised diagnosis prior to his next period of engagement in 2012 (below).

26 June 2012 – 5 December 2012

97. Mr Lock attended six sessions during this period and the primary focus of early sessions was in relation to issues with the children, including S1's continued aggressive behaviour, and the pressure this was placing on Mr Lock who acknowledged during his second session that he had '*become a lot more short tempered as a result of the stress'*.

98. There are no significant disclosures made by Mr Lock during the last sessions of therapy and he appeared to be coping well, looking forward to family activities and holidays.

99. In a report to the GP (dated 6 December 2012), the psychologist states that the major focus of therapy over this period was '*relaxation; insight; psycho-education; normalisation; support; goal-setting; problem solving therapy; interpersonal therapy; systematic desensitisation; and cognitive and*

behavioural techniques and strategies'. He states that Mr Lock would benefit from further therapy sessions.

100. The GP requested further information from the psychologist with a letter sent on 14 December 2012, which outlined 'more specific patient details', as follows:

> *'Mr Lock continued to experience significant levels of stress in the home environment as a result of his Asperger's, his oldest son's condition and behaviour, and the state of his relationship. He has found therapy helpful and it allows him to speak to an independent person about the problems that arise and to be able to explore possible solutions. Mr Lock continues to work on the relaxation techniques learnt in therapy to reduce his physical and emotional reaction to stress. He continues to struggle with his mood as a result of these stressors and finds therapy helpful in thinking differently about his daily problems.*

101. With respect to this period of contact, there is no evidence of any formal mental health assessment being completed by the psychologist despite the lapse of time between sessions, although a K10 assessment, dated 27 February 2012, was provided by the GP which indicated a high score of 36 out of a potential 50 for severe distress. In her referral, the GP cites Mr Lock's diagnosis of Asperger's Syndrome, as well as category B personality traits; and indicates he had ceased Lexapro medication of his own volition.

3 April 2013 to 9 December 2013

102. Mr Lock was referred by the GP for a further six sessions with the psychologist on 8 March 2013 primarily because of '*recent increase stress with S1 now incarcerated for misdemeanour*' and as Mr Lock '*feels he needs to offload – conflict at home'.* The GP suggested on her referral letter '*See K10. Try Valium 2mg daily in view of anxiety and restlessness'.* The K10 indicated a score 38 out of a possible 50.

103. The first sessions focused solely on S1's recent offending and the impact this has had on Mr Lock and the children with no significant or concerning disclosures.

104. In June 2013, Mr Lock disclosed that he '*had a stand up argument with his wife – says she doesn't do anything for him'* and that he feels unappreciated at home by the children.

105. In December 2013, Mr Lock attended and disclosed a significant decline in his mental health and cited more serious issues with Ms Lock. The clinical notes state:

- '*he had been taken to mental health ward for a couple of weeks', 'had tried to hang himself'* and that '*he had enough of being ignored and misinterpreted'*
- *'is angry with Ms Lock with the way she is treating him'* and '*frustrated with Ms Lock's behaviour due to an association with a friend'.*

106. The treatment notes state: '*what would suicide do to his children', 'want out of life', 'focus on being a good father'* and *'motive'.*

107. There is no evidence that the psychologist sought further information pertaining to Mr Lock's suicide attempt or undertook a formal risk assessment at this time; or indeed throughout this period of therapy.

108. On 9 December 2013, the psychologist wrote to the GP and reported that Mr Lock had attended six sessions with the major focus of therapy on relaxation; insight; psycho-education; normalisation; support; goal setting; problem solving therapy; interpersonal therapy; systematic desensitisation; and cognitive and behavioural techniques and strategies.

109. He also noted that Mr Lock had '*reported he had been in the mental health unit due to a suicide attempt. He stated his home life had reached a critical point where he could no longer cope with the relationship breakdown. He reported the suicidal thoughts have eased off since commencing his current medication and has started to explore what he needs to do in the future.* The psychologist

recommended referral for a further six sessions under a new Mental Health Care Plan.

110. The GP referred Mr Lock again, and provided a K10 assessment with a (worsening) score of 39 out of 50; and provided some further information about the nature of Mr Lock's recent suicide attempt as follows:

> '*about 1 month ago, 'lost it', was going to ring* [Dr J]; *S1 was sentenced – Ms Lock – tried to hang himself – D1 came in shed as he was about kick ladder away – 'had had enough' – was admitted to Mental Health Unit for 2 weeks Dr R as well as PHO.*
>
> *Feels has levelled out to a point that would NOT take his life but happy with life.*
>
> *Ms Lock blames him for everything – 'sick of always being the a…hole' – JW church "the elders know what they are doing' despite no training, very elitist attitudes and want whole family involved – does not agree with everything that is said – does go to the meetings because the children – D1 embraces it the most – T is kind with a great heart, slow to anger; D2 is 17 years old and a bit rebellious and shouting at Ms Lock, search for own truth'.*

111. The GP further notes that she had requested mental health records relating to the admission.

13 January 2014 to 30 September 2014

112. Mr Lock returned on 13 January 2014 and reported ongoing frustration with the prison system regarding S1. He further stated that '*Ms Lock told him yesterday she was only there for the children'* and that '*she was embarrassed that he found it difficult to intermingle'.* Mr Lock said he was taking a step back to consider his relationship and had thought about getting a unit for him and S1. The notes indicate '*mood is stable overall'.*

113. On 17 February 2014, Mr Lock reported that the couple had separated and the house had been put on the market after Ms Lock asked him to leave.

114. Although it is somewhat vague, the notes indicate there may have been some discussion around Mr Lock's abusive behaviour although he also made reference to the abuse Ms Lock had experienced as a child. The notes state '*Says he has a large range of emotions come up when Ms Lock called him on the abuse'* which suggests she may have confronted him about his behaviour. It is also noted that '*the children have been filling him in on what Ms Lock says about him'.*

115. At the next session, on 17 March 2014, Mr Lock said the house had sold in nine days and he was currently looking for accommodation for himself and S1 (due for release on parole). Mr Lock stated that Ms Lock had found a place to rent and he '*said he spoke to her about the abuse she experienced'* although it is again unclear if this was in relation to Mr Lock's abuse or her childhood experience. Mr Lock reported some anxiety but that he was coping with it. He also said the couple '*had the* [church] *elders speak to them'* but this hadn't gone well as Ms Lock didn't trust men or the Elders[7].

116. The next appointment did not occur until 1 July 2014 at which time Mr Lock reported that he was living upstairs with Ms Lock (although they remained separated) and that he was mostly staying there for the children, especially D1; that S1 was due to be released on parole in August; and that he had purchased a new motorbike which had lifted his mood.

117. On 12 August 2014, Mr Lock reported that S1 had been released from prison and there appeared to be a separation in the family in that D1 was siding with her mother, and S1 and D2 had sided with him. He reported feeling '*cheated that Ms Lock has turned her back on him'*.

118. Although the psychologist indicates Mr Lock attended six sessions between 13 January and 30 September 2014, only five sessions are documented in the records and there are no notes which confirm whether Mr Lock attended the sixth session and, if so, what was discussed.

[7] There is no corresponding evidence currently available to confirm contact with church representatives.

119. In a letter to the GP dated 4 November 2014, the psychologist states that '*Mr Lock reports therapy has been helpful and the recommended strategies are being implemented. Mr Lock continues to experience high levels of stress and anxiety due to his current family situation. He reports his mood continues to steadily improve as a result of his medication but he is still struggling with a number of stressors in life such as his eldest son and marital status.'*

120. The psychologist recommended further sessions.

121. A similar letter was on file dated 16 December 2014 which slightly expands upon Mr Lock's mental health by adding the paragraph, '*His oldest son has returned home from jail and is in the process of reintegrating into society. There has been added stress at home between the eldest son and his mother due to the son's past values and behaviour. Mr Lock completed a Depression, Anxiety and Stress Scale (DASS) which indicated his depression and anxiety was in moderate range and his stress in the severe range'.*

122. This test is not on file and there are no other formal mental health assessments recorded.

Bethesda Clinic – Mr Lock

123. Mr Lock attended one session with psychiatrist Dr J on 15 July 2009 in which he advised that his wife had left him about 18 weeks ago due to his regular cannabis use. The clinical notes indicate that Mr Lock was diagnosed by Dr J with Category B personality traits in addition to Asperger's, although Dr J noted it '*much more likely narcissistic and anti-social'*.

124. Dr J advised the Queens Park Medical Centre of this diagnosis and stated that pharmacotherapy was not perceived beneficial but ongoing contact with his psychologist was supported.

125. There is no evidence in the Bethesda Clinic or the psychologist's records of direct contact between the psychologist and Dr J however the GP did outline Dr J's revised diagnosis in a referral letter provided to the psychologist in June 2012.

Maryborough Base Hospital – Mr Lock

126. Mr Lock had previously been a patient of the Maryborough Base Hospital (MBH) for unrelated physical ailments, however notable relevant episodes of contact include:

- inpatient admission between 16 November and 27 November 2013 following Mr Lock's suicide attempt
- outpatient contact in April and May 2014
- outpatient contact between 1 and 6 September 2015, a week prior to the deaths.

127. By way of brief summary, although there was evidence of an appropriate standard of care being provided, a number of potential issues have been identified with the following, including:

- limited exploration by clinical staff of domestic and family violence despite the circumstances surrounding Mr Lock's initial admission and knowledge that police had applied for a protection order in November 2017
- lack of independent collateral information sought from Ms Lock to confirm/exclude domestic and family violence or for the purposes of making any assessment of Mr Lock's risk of harm to self or others
- nomination of Ms Lock as an allied person without consideration of the above
- discharging Mr Lock into Ms Lock's care for visitation and release despite recent evidence of violence and ongoing conflict in the relationship (which had triggered the suicide attempt only days before)
- lack of stringent follow up with Mr Lock after his discharge including by communicating with GP
- apparent limited attention given to disclosures of 'violent thoughts' in April 2014.

128. It is also the case that Mr Lock's GP referred him back to the MHU a mere ten days before the deaths which, based on the contents of his handwritten diary, was likely a period of heightened mental instability however this was not

detected during an assessment conducted on this occasion. Again, opportunities to seek collateral information from others may have provided some further insight into Mr Lock's mental state; which may have informed assessment, particularly since it is known that Ms Lock was fearful of Mr Lock up until her death.

16 November to 27 November 2013

129. Mr Lock was taken to hospital by the Queensland Ambulance Service (QAS) after attempting suicide by hanging in the family home on 16 November 2013 (outlined above) under an EEO.

130. The admission notes indicate '*strong suicidal intent and plan'* and superficial cuts were observed on his forearms and lower leg. Mr Lock denied any drug use but confirmed he had consumed a bottle of bourbon prior to the episode.

131. While waiting for a mental health assessment, Mr Lock absconded from the emergency department. Despite attempts by hospital staff to chase him, he ran from the hospital grounds before police were notified he had left.

132. The following day, 17 November 2013, Mr Lock returned home and as noted previously, keyed Ms Lock's car. He then made several phone calls telling her if she didn't return home he would burn the house down and/or kill himself. Police subsequently responded and transported Mr Lock back to the MBH.

133. An intake assessment was completed with the clinical notes indicating Mr Lock exhibited low mood, lack of sleep, psychomotor retardation, fluctuating self-harm ideation, poor motivation and judgement, and a lack of insight. Mr Lock disclosed he had felt depressed for over two years but found anti-depressants made him agitated and aggressive. He cited stressors including S1's incarceration, marital disharmony and discord with religious beliefs.

134. Mr Lock also acknowledged he had previously been violent towards Ms Lock early in their marriage claiming he had anger management issues which were exacerbated by alcohol and cannabis use.

135. Mr Lock was assessed as high risk of suicide and admitted as an involuntary patient under the then *Mental Health Act* 2000 (Qld) (MHA 2000) to the mental health unit (MHU) on 17 November 2013.

136. The clinical notes indicate that he nominated Ms Lock as his allied person[8] and she was contacted and agreed to this on 18 November 2013.

137. Mr Lock was under observation by nursing staff over the next few days and risk assessments were completed which noted his recent suicide attempt as a significant risk factor although he ceased expressing suicidal or self-harm intent shortly after his admission. There is evidence that Ms Lock and the children visited Mr Lock during this period.

138. On 19 November 2013, a review of Mr Lock's mental health status was completed and he was ceased as an involuntary patient after it was noted he had been *'compliant with medication, assured safety and wellbeing for continued care and admission'.* Drug testing had been completed which was positive for cannabis.

139. During his admission, Mr Lock was started on anti-depressant medication which appeared to have a positive effect, with the discharge notes stating '*Mr Lock responded well to the anti-depressant. His sleep improved. No appetite issues were reported. No signs of psychosis were seen. Mr Lock's insight improved and he denied ongoing suicidal ideation'.*

140. On 21 November 2013, Mr Lock spoke with ATODS staff who provided education about drugs and alcohol reduction and abstinence programs. Mr Lock stated he did not have a problem, citing a reduction in his usage and the support of his psychologist as appropriate to manage this issue.

141. That same day, Mr Lock requested a period of leave so he could return home and attend to tasks in the home. After a risk assessment and lengthy discussion with Mr Lock about the need to ensure adaptive coping strategies were utilised and his recent suicide attempt, the clinical notes indicate that

[8] Under sections 341 and 342 of the previous MHA 2000, involuntary patients were afforded the right to nominate any adult who is willing, readily available and capable to be their allied person. The allied person is able to provide and receive information about the patient's care.

leave was approved '*in care of wife'* and that '*Mr Lock and wife agreeable to same'.*

142. Mr Lock returned to the ward after approximately two hours reporting that '*it went well'*. A family meeting was scheduled for the following day and Ms Lock agreed to attend.

143. On 22 November 2013, the family meeting occurred with Ms Lock present. The clinical notes state:

- *'Pleasant apparent interaction between husband and wife'.*
- *'Ms Lock is happy for Mr Lock to come home for the weekend as Mr Lock wants to go and spend time with the kids too'.*
- *'Feels safe and no ongoing self-harm ideation. Says it was "a moment of madness" and would not do it again'* and indicated that '*in case of concerns would talk to Ms Lock or call Mental Health'.*
- *'Ms Lock is open to couple counselling and therapy in the future'.*

144. Weekend leave into Ms Lock's care was approved and commenced that day. When Mr Lock returned to the ward on 25 November 2013, he said that '*leave went well with his children, but not with his wife'* and reported *'a clash about the topic of joint counselling – wife is not interested due to her JW beliefs'.* The notes indicate that Mr Lock said he was considering a separation however he was '*reluctant to do so asap even though he is unable to guarantee his safety and impulsivity if he goes back to the same situation'.* He denied suicidal thoughts on the unit but reported '*fleeting thoughts at home'*. The notes indicate that the nurse '*advised to start thinking of separation/exit plans as opposed to suicide. His children are his protective factors, low risks on MHU'.*

145. By the afternoon of 26 November 2013, Mr Lock reported feeling that he was improving slowly. He said he was '*unsure of where his future lies and what he is going to do'.* He said he '*would like to be able to sort things out with wife, however due to religious beliefs (wife) and communication issues and wife not really wanting counselling'.* He denied any risk issues and was assessed as low risk of suicide/self-harm. Mr Lock was disappointed that he had not seen his doctor since returning to the ward. Later that day, Ms Lock visited Mr Lock

on the ward and the notes suggest '*they were observed to interact well'* although Mr Lock later said this was '*superficial'*.

146. On 27 November 2013, a patient review was completed in the presence of Ms Lock before Mr Lock was discharged from the ward. The notes state:

- '*Questioned about counselling and couple willing'.*
- *'Advised about working towards keeping the relationship'*
- *'No suicidal ideation ongoing'*

147. The discharge summary indicates a follow up appointment was scheduled with Maryborough Community Mental Health on 3 December 2013 and Mr Lock was discharged into Ms Lock's care.

148. On 29 November 2013, the MHS made a phone call to Mr Lock to check on his wellbeing. He denied current low mood and said the new anti-depressant medication appeared to be working. He reported feeling sick from the flu but stated he did not need to see his GP when queried. The notes conclude '*Mr Lock states that he has nil suicide ideation or self-harm thoughts and that he intends to follow up with his appointment at RMO clinic on Tuesday at 13:30'.*

149. On 3 December 2013, Mr Lock attended for review with the Consultant Psychiatrist. The notes indicate that no issues were identified and Mr Lock noted he was going on holiday for three weeks and '*happy to continue medications and willing to follow up by Dr R or ACT'.* The notes state that '*case manager will liaise with him before discharging to GP for further follow up'.*

150. It appears that two phone calls were made, on 16 and 17 December 2013, with neither being successful in reaching Mr Lock.

22 April to 28 May 2014

151. A referral letter, dated 22 April 2014, from the GP was sent to the MHU which requested a mental health review and stated:

> *This man had an admission to your unit 27/11/2013 and was to be followed up but has not received an appointment to this date.*

He reports that he has had a lot of violent thoughts[9]. Denies drug use. He is taking Mirtazapine.

152. A handwritten note on this letter states '*19/5/14 No word from Mental Health'.*

153. On 21 May 2014, a social worker called Mr Lock however he was not home. The notes suggest that Mr Lock's daughter (unidentified but presumably D1 as D2 was living in Tasmania at the time) answered and said she didn't have her father's mobile phone number. They left a phone number and asked her to pass a message on to Mr Lock to return their call.

154. Mr Lock called back that same day and the notes indicate: '*low tone angry self reports that he was promised follow up and had not heard from post discharge on 27th November 2012'.* The notes indicate that the social worker '*reminded Mr Lock of the discussion with the RMO Dr quoted the date and time he was seen and the subsequent referral back to the GP, then S* [Mr Lock] *went on holiday for 3/52. Mr Lock said 'oh I don't remember that!'.*

155. The mental health assessment notes indicate that:

- '*Mr Lock states that he is still suffering from depression, is compliant with Mirtzapine 30mg and reports to have vague suicidal thoughts off and on'.*
- *"Sometimes safe, sometimes not, sometimes think the easy way out is a good option!"*
- *'States "Trigger seems to when things seem hopeless!"*
- Mr Lock cited stress related to the recent sale of his home and having to move and said his wife was '*supportive of others who have my illness but is not understanding of me!".*
- Mr Lock reported his mood '*cycles through anger and sadness, currently rates his mood as 3-4/10'* and said '*he don't like life or people'.*
- He reported low energy and appetite, and said he had lost one to two kilograms over a few months.
- He reported that he had stopped using marijuana in November 2013 and drank one to two scotches per week.

[9] This is not explicitly reflected in the GP's clinical notes.

- Mr Lock said he was still engaged with the psychologist once a month.

156. The social worker concluded that '*Mr Lock sounds angry and entitled'* and noted that Mr Lock reported his GP finds him '*difficult to handle'* and had said it was '*easier to just leave me on Mirtazapine because it works'.* Mr Lock said he is '*always anxious and depressed describes panic as stomach doing flip flops'.*

157. Mr Lock was assessed at medium risk for suicide, self-harm, aggression and vulnerability and the social worker noted his case would be discussed at the next intake meeting with a full review meeting booked for 27 May 2015. Mr Lock was advised to call if he felt '*unsafe'*.

158. Mr Lock presented on 27 May 2015 for a formal mental health review. He again disputed the discharge plan and lack of follow up by the MHU. He reported that Ms Lock did not participate in couple's counselling as planned but that he still saw his counsellor weekly.

159. The notes indicate that '*Mr Lock presented to mental health due to his vague and intermittent thoughts of suicide which he states is triggered by anxiety'.* He reported stressors about the recent sale of the family home; a lack of communication with Ms Lock although they continued to live together; and ongoing problems regarding S1 who was due to be released from prison soon. Mr Lock said his mood was '*mostly negative with nothing much positive'* and no auditory or visual disturbance, and no formal thought disorder was noted.

160. Of significance, the clinical notes also indicate Mr Lock remained preoccupied with Ms Lock's childhood experience of abuse:

> *Felt it was his duty to bring wife's past sexual abuse out in the open with alleged abuser. This was not accepted by wife. Mr Lock believed that his wife and [the abuser] colluded prior to him disclosing this information. Mr Lock (shrugged) they said it was consensual, but I didn't believe it. Mr Lock states he "tried to bring it all out in the open for her!"".*

161. With respect to the violent thoughts cited by the GP in her referral letter, the notes state '*GP reports client has violent thoughts but client denies this at interview'.*

162. Although Mr Lock was assessed as medium risk by the social worker, the plan did not include further follow up with the MHU though it was noted Mr Lock would like a medication review and would continue engagement with his GP and psychologist. The notes indicate '*Mr Lock was encouraged to call mental health if his anxiety increased to the point of feeling unsafe or suicidal. Mr Lock agreed that he would attend the emergency department, speak to his GP or his counsellor'.* Mr Lock also noted he would approach the Department of Housing to seek out suitable accommodation for him and S1.

163. On 28 May 2014, this assessment and plan was discussed with Dr R, who agreed. The social worker has noted that this plan was fed back to the client.

1 to 7 September 2015

164. On 1 September 2015, the GP again referred Mr Lock for review by the MBH MHU noting '*past history of major depression with presentation yesterday with anxiety/depression precipitated by marital separation'.*

165. An intake assessment was completed on 3 September 2015 via phone call between a registered nurse and Mr Lock. The notes are as follows:

> *P/C to Mr Lock. Mr Lock confirms he has had recent separation from his wife of 31 years. She has also taken his youngest child who does not want anything to do with him. He says that this has caused a major disruption in his life and for the first time in 31 years he is alone. He recounts his wife disclosed to him many years ago that she had been molested by an elder in her church when she was very young. When this stopped she says that [Y] molested her when she was a teenager. Mr Lock says that he has tried to confront this elder but he is deceased and she has just moved in with her brother and his wife. His youngest daughter who is 15 is also living with them… This situation has Mr Lock ruminating all the time what is happening to his youngest daughter.*

He says that he does not know what to do with himself now that he is alone. He says that he does not have much control over the situation and this is getting to him. He finds himself thinking all day and this is getting him down… He says that his 'guts are churning' and he does not feel like eating… He says sleep is disturbed as he is ruminating about his separation… he is also drinking prior to going to bed to help 'wipe out' the thoughts.'

166. The RN concluded there was '*no evidence of thought disorder*' and noting referral had been made to the psychologist, the plan was made to refer Mr Lock to Lifeline for general counselling and for Mr Lock to follow up with his psychologist: '*Crisis management discussed with Mr Lock and he is aware of how to contact our service should he need to'* and short term follow up was arranged until he was linked in with these services and then his file would be referred back to the GP.

167. A phone call was then made to the GP with the notes indicating '*Discussed intake phone call from this morning. She will continue care and our service will provide short term follow up'.*

168. On 7 September 2015 the registered nurse contacted Mr Lock for follow up. The notes for this phone call state:

'Says that he is going 'ok'. Had a good weekend. Went to the movies and enjoyed this. Denied any thoughts to harm himself although still angry with the current situation. Trying to keep busy as this will distract him from thinking about his loss. Sounded upbeat over the phone. Has not called Lifeline yet but will call them today. Has their phone number as it was SMS to him. Thanked us for the call and support'.

169. A follow-up phone call was planned however the deaths occurred three days later prior to this occurring.

JEMA Clinic – Mr Lock

170. Mr Lock attended this clinic on 30 August 2015 seeking Viagra stating he was going on a holiday and was experiencing sexual difficulties. A prescription was provided as well as advice about maximum dosages. This is significant as Mr Lock did not see his regular GP for this request despite being well engaged and had made no prior disclosures about sexual dysfunction; and further, there was some evidence in his handwritten diary that he intended to drug B with Viagra and force him to have sex with Ms Lock, with the deaths occurring less than two weeks later. It is, however, noted that Mr Lock did indicate a loss of libido to the psychologist in 2010.

Queens Park Medical Centre – Ms Lock

171. Ms Lock was also a patient of the GP at the Queens Park Medical Centre between 1999 and 2015, during which time she presented for a range of physical and mental health concerns, commonly related to family stressors.

172. Of significance:

- Ms Lock first disclosed her experience of childhood sexual abuse, memory loss and depression in 2009 citing her difficulties with Mr Lock's mental health and the children's behavioural issues as a significant stressor
- The GP established a mental health care plan with Ms Lock in 2009 but she felt unable to discuss her personal issues with a psychologist and did not pursue this avenue of treatment despite encouragement
- In 2012, Ms Lock reported:
    - extreme stress regarding S1 and his behaviour, particularly the aggression demonstrated towards the younger children
    - memory loss which was considered to occur in the context of the aforementioned stress but there was a strong family history of Alzheimer's Disease noted
    - two prior episodes of collapse after feeling light headed and dizzy.
- The GP completed routine tests and these were found to be normal.

- In 2013, Ms Lock returned to the clinic and said she was struggling for breath, felt tired but was not sleeping well. The GP referred her to a neurologist.
- Specialist progress notes were provided to the GP during this period which outlined there was no underlying organic pathology for the above issues despite extensive investigations. The neurologist advised he had suggested psychiatric assessment to rule out underlying issues such as depression or anxiety however Ms Lock said she had previously been uncomfortable in doing so. The specialist suggested referral to another psychologist/psychiatrist to exclude underlying psychogenic causes of her discomfort.
- In June 2015, Ms Lock returned to see the GP, with the clinical notes indicating:
    - Ms Lock '*needed someone to talk to'* as '*life at home is not working'.*
    - Mr Lock had '*lost the plot'* and gone into the mental health unit in October 2014 and Ms Lock further went on to outline a history of controlling behaviour and emotional/verbal abuse by Mr Lock although she did not disclose a protection order was established as a result of this episode.
    - Mr Lock had attempted to hang himself in front of D1.
    - Ms Lock had attempted to leave Mr Lock in March 2014 however he had nowhere to stay and so had '*sweet talked her into staying'* and was living with her and the kids
    - Ms Lock felt '*frustrated rather than depressed – guilt about breaking up family – not in her plan'.*

173. With respect to Ms Lock's contact it is apparent that the GP demonstrated some empathy towards her patient[10], however it is also the case that she did not seek to undertake any screening or exploration of potential risk of future harm, or refer Ms Lock to a specialist domestic and family violence support

[10] For example, the GP said her patient 'deserved a medal' for tolerating the amount of stress in the family home in a Centrelink exemption letter.

service despite her awareness of increasing conflict in the home and Mr Lock's suicide attempt in November 2013.

174. There is also no evidence of follow-up by the GP after the neurologist recommended referral to another psychologist despite his view that further assessment was required to rule out underlying psychological distress as the reason for her falls and memory loss.

Maryborough Base Hospital – Ms Lock

175. Ms Lock had a history of admissions in relation to obstetric and gynaecological issues; however her referral to a neurologist in December 2013 is of particular relevance.

176. After undertaking extensive investigations into potential causes for Ms Lock's memory loss and falls, the neurologist formed the view that the underlying issues were perhaps psychosomatic and noted that he had recommended further follow up and referral from the GP, as evidenced in his letter to the GP, dated 9 December 2013.

177. He advised the GP that Mr Lock had attempted suicide two weeks earlier and this was causing a lot of stress for Ms Lock. There was no further follow-up arranged and the neurologist indicated this would be the case in his letter to the GP as he was referring the matter back to her for follow up.

Maudsland Medical Centre - Ms Lock

178. Ms Lock attended two appointments at the Maudsland Medical Centre after moving to the Gold Coast in 2015, as follows:

- 31 July 2015 – Ms Lock advised she had moved from Maryborough and was seeking a letter for Centrelink outlining that she was unable to look for work as she had just left an abusive relationship. The doctor declined to write a letter at this time but requested medical records from the Queens Park Medical Centre to make a determination.

- 4 August 2015 – a different GP advised Ms Lock on her return that there was no evidence of any 'chronic health condition' that could justify a letter to Centrelink apparent in the Queens Park Medical Centre records which had been received and reviewed. The notes state she was '*distressed and can't look for work'*. The notes state '*explained to pt that we can start look into her condition and help by offering treatment and mental health issues, but pt was in rush to have her certificate and denied any medical assistance'.*

179. This response is problematic for several reasons, however most significantly the Queens Park Medical Centre records provide evidence of Ms Lock having a major depressive disorder; a family history of mental illness; a history of childhood sexual abuse and there was evidence that the GP had previously provided a detailed exemption from Centrelink because of the stress she was experiencing at home.

Michigan Drive Medical Centre – Ms Lock

180. Ms Lock attended this clinic on 6 August 2015 to report that she was unable to sleep because of her recent marriage breakdown with an abusive partner which had prompted her to move from her home town of Maryborough. She stated she had insomnia and '*is crying'*.

181. The GP provided a medical certificate for Centrelink citing her primary condition and diagnosis as 'Depression related to abusive marriage breakdown'. The certificate indicated she would be unable to look for work or complete other duties until November 2015.

182. A prescription for sleeping medication was provided but there was no evidence in the records of an attempt to refer Ms Lock to other services or encourage further engagement.

Adequacy of Service System Supports

183. The DFVDRU concluded that in relation to the contacts that Ms Lock and Mr Lock had with service support systems there were elements of good practice and also practices and responses that caused concern, as set out below.

Primary health care providers

184. Both Ms Lock and Mr Lock had contact with GPs.

185. The elements of good practice by the GPs identified by the DFVDRU were formal mental health risk assessments and appropriate referral and follow up of specialist services, including that the GP referred Mr Lock to the mental health unit of the hospital for formal assessment stating he had been having 'violent thoughts' in the context of his recent separation from Ms Lock.

186. The issues identified were:

- The capacity of practitioners to recognise the detrimental impact of domestic and family violence on victims across health, social and economic domains. For example, a GP refused to provide Ms Lock with a certificate of exemption to Centrelink based on her experience as a victim of violence despite documented evidence of this which had been provided by her former GP who had previously provided an exemption letter to Centrelink.
- Limited evidence of referral to broader support services, including with regards to accommodation needs where Mr Lock remained living with Ms Lock after their separation; or when Ms Lock disclosed she had no one to talk to her about her experience at home and may have benefited from referral to a specialist support service.
- Failing to explore or screen for domestic and family violence when there were indicators of violence in the home.
- A GP saw both Ms Lock and Mr Lock concurrently. Although the GP did refer Mr Lock for psychiatric assessment after he disclosed having 'violent thoughts', there is no evidence that she sought to assess or manage any potential risk of harm posed to the family beyond this.

- The degree to which direct or indicative disclosures of abusive behaviour were challenged or explored by GPs and a corresponding lack of referrals.
- both the victim and perpetrator were seen by the same GP over the period of time in which there was an escalation of violence and relevant disclosures made by both parties about domestic violence in the relationship.

187. The DFVDRU noted:

In the inquest into the death of Noelene Marie Beutel, with respect to relationships characterised by intimate partner violence, Coroner Hutton noted the issue of whether a GP should treat one, both or neither party as important, but considered it to be largely unresolved at the time of inquest by current policy or practice guidelines. Accordingly, Coroner Hutton recommended that the medical profession itself, along with the Queensland Government, should explore the issue further with a view to establishing guidelines to assist GPs, extending upon the existing 'Abuse and violence: working with our patients in general practice, 4th edition' guidelines otherwise known as the 'White Book'[11] which were most recently updated in 2014; and constitute the primary resource to guide GPs in their response to victims and perpetrators of domestic and family violence.

Subsequent to this inquest, the Special Taskforce supported the recommendation that the Royal Australian College of General Practitioners (RACGP) refines the RACGP 'White Book' to be more prescriptive and provide more definitive advice and decision making pathways for general practitioners (Recommendation 50). The Queensland Government supported the recommendation in its response to the Special Taskforce report and it was noted that the Health Minister would write to the RACGP in support of this recommendation.

188. At the time of publishing these findings, the White Book remains unedited or

[11] Chapter 5 of the 'White Book' provides practice guidelines on working with perpetrators in clinical practice. Refer: https://www.racgp.org.au/your-practice/guidelines/whitebook/chapter-5-dealing-with-perpetrators-in-clinical-practice/

revised since 2014 and there are no identifiable alternative actions to improve primary health care responses to domestic and family violence currently underway across the state.

Health system responses

189. Elements of good practice included:

- Efforts to maintain continuity of contact with patients eg Mr Lock was frequently engaged with a private psychologist over a sustained period of time and would re-engage during periods where he required additional support.
- Recognition by a neurological specialist that the harmful psychological impact of domestic and family violence may have been the underlying trigger for psychosomatic symptoms experienced by Ms Lock.

190. The following issues were identified:

- Limited evidence of health services seeking and/or having sufficient regard to the views of intimate partners or family members about their experience of victimisation and abuse where the health service became aware that the relationship may have been characterised by violence.
- A reliance on victims as family members to provide ancillary care and support to perpetrators of domestic violence in relation to underlying health issues, including (largely) mental health concerns, eg where Mr Lock nominated Ms Lock as his allied person and was released into her care despite the triggering episode including acts of abuse against her (which was known to the treatment team at the time); and
- The degree to which risk assessment and victim safety was factored into treatment and discharge planning where Mr Lock was discharged into Ms Lock's care;
- The lack of integration, communication and apparent lack of understanding of risk from treating clinicians in the mental health setting when managing complex needs and risk;
- A lack of information sharing between health providers as to diagnoses and treatment strategies where critical information was not relayed

between service providers such as psychiatrists, psychologists and other health practitioners even during periods of concurrent contact.

- An over-reliance on self-reporting and limited evidence of seeking collateral information resulting in risk assessments based on partial or incomplete information across most of the cases.
- Limited attention given to assessing and/or managing potential risk posed to family members even where there was knowledge of historical or recent violence in the home and/or the presence of protection orders,
- Missed opportunities to address underlying issues and factors including mental health and substance misuse problems where Mr Lock's psychologist showed limited attention to his ongoing substance misuse issues over a prolonged period of time.

Responding to dual diagnosis and complexity of need

191. Dual-diagnosis is a term used to describe co-occurring diagnoses of two or more types of mental illness/es and drug related disorder/s. Dual diagnosis is often associated with poorer treatment outcomes, severe illness and high service use; and it is recognised that people with dual diagnosis may have a higher level of risk for suicide, self-harm, aggression and violence[12].

192. Research clearly indicates this cohort is the norm and not the exception, with research suggesting that the prevalence of dual diagnosis ranges from 50 to 70 per cent in mental health settings, and 40 to 80 per cent in alcohol and other drug treatment settings[13]. It is therefore incumbent upon clinicians to respond in an integrated manner and avoid treating one issue in isolation of the other/s.

193. A focus on integrated care, from a clinical perspective, recognises not only the individual issues arising from mental illness and drug disorders but seeks to contextualise responses within the broader psychosocial circumstances and needs of the individual; leading to improved clinical outcomes and a reduction in risk of harm (to self or others).

[12] Queensland Health 2010, Queensland Health Dual Diagnosis Clinical Guidelines, Queensland Health, Brisbane.
[13] Queensland Health 2003, Strategic plan for people with a dual diagnosis (mental health and alcohol and other drug problems), Queensland Health, Brisbane.

194. In relation to Mr Lock, there were limited efforts by clinicians to address his comorbid conditions and a lack of focus given to addressing his continued and significant use of alcohol and marijuana, in conjunction with his mental illness.

195. Although there was some psychoeducation provided about the cumulative impact of harm, there appears to have been only cursory efforts made to refer or address these issues by the psychologist Mr Lock saw for over eleven years.

Diagnosis and clinical response

196. There is evidence that the neurologist was notified of an additional diagnosis of Type B personality traits however this was not accounted for in the treatment strategy, which remained unaltered and largely focused on his initial diagnosis of Asperger's Syndrome.[14] Mr Lock also exhibited symptomology highly consistent with acute psychosis in the weeks prior to the homicide-suicide however there was no evidence of diagnosis or treatment of this issue, during his presentations with relevant services.

197. It is also salient to note that research suggests depression is the most common diagnosis in murder-suicides,[15] and around three in ten homicide-suicide perpetrators had contact with mental health services prior to the deaths.[16]

198. While noting that homicide-suicides are relatively rare, this research, supported by the case examples outlined in this report, highlights a potential opportunity for intervention. As such efforts to enhance gatekeeper training to include more focus on educating clinicians about the possibility of violence towards others as well as to the self so they can better provide support to their clients, and their families may be of benefit.[17]

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14 According to the DSM-5, the Type B cluster of personality disorders include borderline personality disorder, narcissistic disorder, histrionic personality disorder and antisocial personality disorder. Disorders in this cluster share problems with impulse control and emotional regulation, requiring a different treatment approach. It is also noted that these types of disorders have poorer responsivity to treatment and are known to manipulate others.

15 Queensland Health 2010, Queensland Health Dual Diagnosis Clinical Guidelines, Queensland Health, Brisbane.

16 McPhedran, S., Erikkson, L., and Mazerolle, P. (2014) To prevent murder suicide we need to better understand offenders. The Conversation, online at: http://theconversation.com/to-prevent-murder-suicide-we-need-to-better-understand-offenders-31561

17 The Mental Health Sentinel Events Review made recommendations that support this finding, namely: Recommendation 22 – Implement a three level violence risk assessment framework; Recommendation 46 – Consistent with the recommended phased model of risk assessment and management, all clinicians require training in principles of risk assessment of people with mental illnesses. This knowledge is necessary to complete the risk assessment screening required for all consumers. Senior clinicians require training in risk assessment and management necessary to enable them to undertake the level two risk assessments using and interpreting validated risk assessment measures; Recommendation 47 – Training in violence risk assessment, including the administration and interpretation of validated violence risk assessment measures, needs to strengthen formulation skill development and capability to ensure recommendations and care planning meet the consumer's needs rather than being passively identified in documents; Recommendation 48 – provide training and supervision specific to identification of risk factors

Criminal justice system response

199. Police officers identified Mr Lock's suicide attempts and threats as a form of domestic abuse and applied for a protection order accordingly.

Specialist services, and integrated responses

200. The DFVDRU stated:

> *Integrated service responses to domestic and family violence are increasingly recognised as the most effective response to addressing the complex needs experienced by victims and perpetrators; and have flourished in the past decade throughout Australia and internationally.*
>
> *A focus on integration is also a core principle across a range of sectors and underpins policy, program and practice approaches in areas such as health and criminal justice. This arises in recognition of the often complex and co-occurring issues experienced by, for example, people living with a mental illness or problematic substance misuse issues and the associated need to comprehensively address a person's needs across a range of domains, (such as housing, employment, child safety or education).*
>
> *As such, there has long been an onus across sectors to embed integrated practices and pathways to reduce a siloed approach to service delivery and improve a client's outcomes, however implementation continues to be an issue at an operational level.*
>
> *The Gold Coast has had an integrated service response operating for a long period of time. The Gold Coast Domestic Violence Integrated Response is a community based multi-agency response to domestic violence which was established in 1996 to enhance responses following high rates of violence, and domestic homicides within this region.*

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of violence to ensure appropriate escalation processes are included where indicated; Recommendation 49 – Provide training and supervision specific to recovery principles, and the dignity of risk (i.e. the realisation that all people including consumers carry with them some degree of risk and the important factor is how they manage that risk), to ensure treatment plans assist with firstly stabilising the consumer's presentation and working towards recovery which includes addressing violence risk factors; and, Recommendation 50 – Provide training on consumer confidentiality and release of information so that information sharing between the forensic mental health services, other service providers and family/carers allows for open discourse on risk and discovery of important factors to be considered in care planning.

Under this response model, agencies are meant to work together to provide co-ordinated appropriate and consistent responses to women and their children affected by domestic and family violence, and men who perpetrate violence. It operates within a justice reform model, which has drawn on international expertise in its development; and continues to evolve over time.

Whilst Ms Lock was residing at the Gold Coast at the time of her death she had only recently re-located here and there is no evidence that she was linked into a specialist service by any mainstream providers she had contact with. There were examples of ongoing and often concurrent contact with services with very limited evidence of integrated responses which represents a critical missed opportunity to provide more coordinated and targeted support in this case.

Service integration is promoted as an overarching mechanism for providing cohesive and comprehensive responses to victims, and their children, of domestic and family violence. There are identified benefits to clients and service providers to utilising integrated service response models.

To be effective however, integrated responses to domestic and family violence need to involve both crisis and long-term counselling / support, safety planning, health and mental health services, criminal justice services, and where applicable other relevant agencies such as housing and employment services. As such, service integration is promoted as an overarching mechanism for providing cohesive and comprehensive responses to victims, and their children, of domestic and family violence. There are identified benefits to clients[18] and service providers[19] to utilising integrated service response models.[20]

The Special Taskforce on Domestic and Family Violence Final Report made several recommendations with respect to the development and implementation

[18] For example, simplified coordinated response to multiple client needs particularly when they are one-stop shops; multiple entry points for intervention; and, minimisation of secondary victimisation

[19] For example, cost effectiveness achieved through minimising duplication of services; formalised information sharing between services; potential up-skilling of workers across different issues; and, enhanced transparency and accountability between services and workers.

[20] Breckenridge, J., Rees, S., Valentine, K., & Murray, S. (2015). *Meta-evaluation of Existing Interagency Partnerships, Collaboration, Coordination and/or Integrated Interventions and Service Responses to Violence Against Women: State of knowledge paper*. Sydney: Australian National Research Organisation for Women's Safety.

of integrated service response trials informed by Coroner Hutton's inquest findings into the death of Noelene Beutel.[21] *Trial sites were originally implemented in Logan/Beenleigh, Mount Isa, and Cherbourg, with additional sites*[22] *commencing in 2017-18.*

As part of the implementation of these reforms, ANROWS was commissioned to develop a suite of tools to support the integrated service response, including a common risk assessment framework, supporting documentation and information sharing guidelines which are currently being trialled, but are not publically available.

The Queensland Centre for Domestic and Family Violence Research were commissioned to evaluate the trial sites. In July 2016, an 18 month evaluation of the three trial sites commenced.

Prior to the completion of the evaluation the trial sites were expanded to include eight total locations that all use the Common Risk and Safety Framework. Those locations were:

- *Cairns*
- *Cherbourg (initial trial site)*
- *Ipswich*
- *Logan/Beenleigh (initial trial site)*
- *Mackay*
- *Moreton Bay (Brisbane)*
- *Moreton Bay (Caboolture)*
- *Mount Isa/Gulf (initial trial site)*

The evaluation was completed in 2019, though only a summary of the evaluation has been released to date. While Central Queensland University's Centre for Domestic and Family Violence Research was originally contracted to do this work, the final evaluation was completed by Griffith University. Somewhat confusingly, the integrated service response is often interchangeably referred to as 'High Risk Teams' in this document though in

[21] Recommendations 9, 74, 75, 76, 77, 78, 79, 80, 82 and 83 of the Special Taskforce on Domestic and Family Violence. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. Brisbane: Author.
[22] Brisbane, Ipswich and Cairns

reality the high risk teams are only one component of the integrated service response.

The summary document states that numerous benefits were identified by the evaluation including strengthening a focus on victims of domestic and family violence, increased awareness of DFV among government agencies, and some increased focus on perpetrators. The following 'challenges' were also identified:

- *the common approach to assessing risk has developed differently than was intended, meaning that participating agencies are assessing risk differently — this has broadened the scope of work for high risk teams*
- *confusion about the separation of roles and responsibilities of the high risk teams and the broader integrated service system response*
- *confusion around information sharing outside of the role/functions of high risk teams, and a perception among many stakeholders that the high risk team was the only mechanism for information sharing*
- *the need for more culturally appropriate processes and services for Aboriginal and Torres Strait Islander participants and those from culturally and linguistically diverse backgrounds*
- *while there is a significant focus on improving victim safety, this could be strengthened by more focus on perpetrators and holding them to account.*

The evaluation summary identifies 'key suggestions for further strengthening the model' and these include:

1. *Clarifying the different purposes and roles of the integrated service response and the high risk teams.*
2. *Clarifying the different purposes of assessing risk at different points in the service delivery response.*
3. *Supporting an increased focus on perpetrators within the integrated service response model.*
4. *Clarifying and unifying approaches to information sharing between agencies.*

5. *In the context of other key suggestions for strengthening the model, continuing to support sustainable models and processes.*
6. *Embedding a culture of continuous improvement and best practice in integrated responses to domestic and family violence.*

The summary reflects that the high risk team model is in a state of 'emerging practice' and that more needs to be done to 'consolidate and embed these reforms'.

Accessing crisis or alternative accommodation

201. Ms Lock was forced to continue living with Mr Lock post-separation due to financial restrictions and a lack of alternative arrangements.

202. Ms Lock had separated from Mr Lock after an episode of violence in which he had threatened and attempted suicide, and threatened to burn down the family home in November 2013. Following this, he was admitted as a mental health inpatient however ultimately was released into Ms Lock's care. After the family home was sold, Ms Lock moved into a rental property with D1, however, it is apparent that Mr Lock continued to cohabitate with her as he was unable to find or afford accommodation. Ms Lock was forced to seek assistance from her brother to move out of the home and ultimately moved in with his family out of necessity to escape the abuse.

203. Mr Lock was able to maintain contact with Ms Lock and D1 through their shared living arrangements after their separation and this not only increased her exposure to ongoing risk but is likely to have caused further trauma to her and D1.

204. The Australian Government has invested funds into the 'Keeping Women Safe in their Home' project, to improve frontline support and services, leverage innovative technologies to keep women safe and provide education resources to help change community attitudes.

205. The Australian National Research Organisation for Women's Safety (ANROWS) also recently undertook a national mapping and meta-evaluation

project outlining key features of effective 'safe at home' programs that enhance safety and prevent homelessness for women and their children who have experienced domestic and family violence.[23]

206. This research identified that 'safe at home' strategies are not intended to supplant refuges of specialist homelessness services, but to complement these, and to provide a safe option for women who refuse to uproot their lives by fleeing the family home. The four pillars of effective safe at home responses identified were:

- maximising women's safety – using a combination of criminal justice responses including proactive policing, safety alarms, home security upgrades, and legal provisions to keep the perpetrator from the home;
- preventing homelessness – includes ensuring women are informed about their housing options before crisis, and providing support for women to maintain their housing afterwards;
- importance of an integrated response involving partnerships between local services; and
- enhancing women's economic security.

207. Specialist services should ensure they follow these principles when developing safety plans for victims who remain within a shared residence, or where the perpetrators know where they are residing. There is no evidence of any safety upgrades being undertaken by specialist services as part of their planning processes in any of the cases within this report; or reviewed by the DFVDRU to date.

208. The Queensland Government has also enacted a range of reforms following the Special Taskforce on Domestic and Family Violence to improve housing outcomes for victims of domestic and family violence. This reform, led by the Department of Housing and Public Works (DHPW) and Department of Communities, Child Safety and Disability Services (DCCSDS), aims to improve accessibility and affordability of housing for female victims and their children

[23] Breckenridge, J., Chung, D., Spinney, A., & Zufferey, C. (2016). *National Mapping and Meta-evaluation Outlining Key Features of Effective "Safe at Home" Programs that Enhance Safety and Prevent Homelessness for Women and their Children who have Experienced Domestic and Family Violence: Research report*. ANROWS: Sydney.

who experience domestic and family violence in recognition that this is a key contributor to homelessness.

Common Risk and Safety Framework

209. The Common Risk and Safety Framework was released in 2020. It was accompanied by an announcement that *'a revision of the Framework is currently underway, in response to an independent evaluation completed in 2019 which made recommendations for further strengthening the Framework. Validation of the Framework is expected to occur as part of this revision. Agencies and services should take this into consideration when deciding how they use Version 1 of the Framework to support their responses to DFV'.*

210. The framework consists of three tiers of risk assessment:
    - Level 1: Routine asking about domestic and family violence
    - Level 2: Risk assessment and referral to a high risk team
    - Level 3: Multiagency risk assessment and safety plan completed by a high risk team

211. While acknowledging the framework is being revised, the DFVDRU identified some general preliminary concerns with the document:
    - *proposed tools lack scientific rigour to be able to predict future episodes of violence or homicide. While most of the risk factors listed in the risk assessment tool are evidence-based and have been shown to be associated with future harm and lethality, the interconnectedness between factors has not been considered.*
    - *The level 2 risk assessment tool is long and lacks usability for generalist and specialist support workers. The tool consists of some 51-items, plus open-ended questions about the victim's perception and professional judgement. Given that this tool is intended to be utilised in frontline situations (for example with emergency department social workers or police), when staff are responding to crises, the ability to complete the assessment in a timely and robust manner is compromised, and likely unrealistic in certain settings. A Victorian review of their equivalent*

framework identified that the length of the assessment was a limitation to the usability of the tool. The Queensland tool is twice as long as the Victorian tool (51 questions vs. 26 questions).

- *The level 2 tool is titled 'domestic violence risk assessment and safety planning'; yet protective factors are absent within this tool. This information would be particularly important with respect to safety planning for a victim, to ascertain what strengths and supports they have available to them to help mitigate future risk of harm (i.e. social supports, access to finances).*
- *While recognising the presence of vulnerable populations, the tools have not been developed to consider the risks and needs of priority populations, which by definition, have greater vulnerability to domestic violence (including lethal acts of violence). Of particular concern is the lack of consideration of the factors which are prevalent for Aboriginal and Torres Strait Islander women who are victims of violence. There is no consideration of how Aboriginal and Torres Strait Islander women use violence to a greater extent than non-Indigenous women as a means to protect themselves, and what the implication may be for their presentation at services. The presence of these factors has the potential to impact on the ability of services to adequately assess for risk and provide a culturally appropriate response for Aboriginal and Torres Strait Islander victims, and perpetrators, of family violence.*
- *Furthermore, the tools do not consider family violence, perpetuating the misconception that intimate partner violence is the prevailing form of violence in domestic settings. There is a view that the service system struggles to address needs of victims, or perpetrators, of family violence. The Common Risk and Safety Framework and Integrated Service Response as designed does nothing to explicitly address this.*

212. Other relevant actions undertaken to alleviate housing stress and homelessness for women and their children escaping violence include:

- Automated bond loan approvals for clients experiencing domestic and family violence who have verified their circumstances.

- Improvements to the Housing Needs Assessment tool to help the government more easily identify women and children affected by domestic and family violence.
- Clarification with Domestic and Family Violence Specialist Homelessness Services that clients experiencing domestic and family violence can expect to receive a range of support from Housing Service Centres in relation to bond loans and rental grants; Rent Connect services; social housing assistance; and, tenants and management of social housing tenancies.
- Development and distribution of information to Housing Service Centre staff that details and clarifies housing assistance available for clients impacted by domestic and family violence.
- Engaging with Housing Service Centre staff to strengthen knowledge and understanding of the assistance and available support services to ensure that appropriate and timely referrals can be made when needed.

Bystander interventions

213. Mr Udinga attempted to intervene after seeing Ms Lock and Mr Lock struggling in the car and hearing a loud noise (gunshot) on the morning of the fatal assault. At great risk to himself, Mr Udinga tried to assist when Ms Lock escaped the car and made her way into the restaurant. He is to be commended for his act of bravery and selflessness.

Conclusions

214. I find that Ms Lock died from a gunshot wound to the head which was inflicted on her by Mr Lock.

215. Mr Lock died from a self-inflicted gunshot wound to the head. His death was due to suicide.

216. I agree with the conclusions of the DFVDRU. Overall, there were examples where support services, health systems and the Queensland Police Service provided a high level of assistance and support to Ms Lock. However, the support provided by services was insufficient to protect her from Mr Lock as was the Domestic Violence Protection Order which was in force. A more integrated approach may have made a difference to the tragic outcome, however, it is unlikely to have done so.

217. Reforms to domestic abuse support services and laws continue to be identified and implemented and, in Queensland, are currently the subject of a taskforce chaired by The Honourable Margaret McMurdo AC.

Findings required by s.45

Identity of the deceased –	Karina May Lock and Stephen Glenn Lock	
How they died –	Karina Lock died from a gunshot wound to the head inflicted on her by Stephen Lock. He then shot himself in the head which resulted in his death	
Place of death –	Karina May Lock: McDonalds Restaurant, 14-20 Siganto Drive HELENSVALE QLD 4212 AUSTRALIA Stephen Glenn Lock: Gold Coast University Hospital SOUTHPORT QLD 4215 AUSTRALIA	
Date of death–	Karina May Lock: Stephen Glenn Lock:	10/09/2015 11/09/2015
Cause of death –	Karina May Lock: Stephen Glenn Lock:	Gunshot wound to head Gunshot wound to head

I close the investigations.

Jane Bentley
Deputy State Coroner
CORONERS COURT OF QUEENSLAND - SOUTHERN REGION

10 September 2021